Status of Reproductive Health and Family Planning in the Graueri Landscape in Eastern Democratic Republic of the Congo

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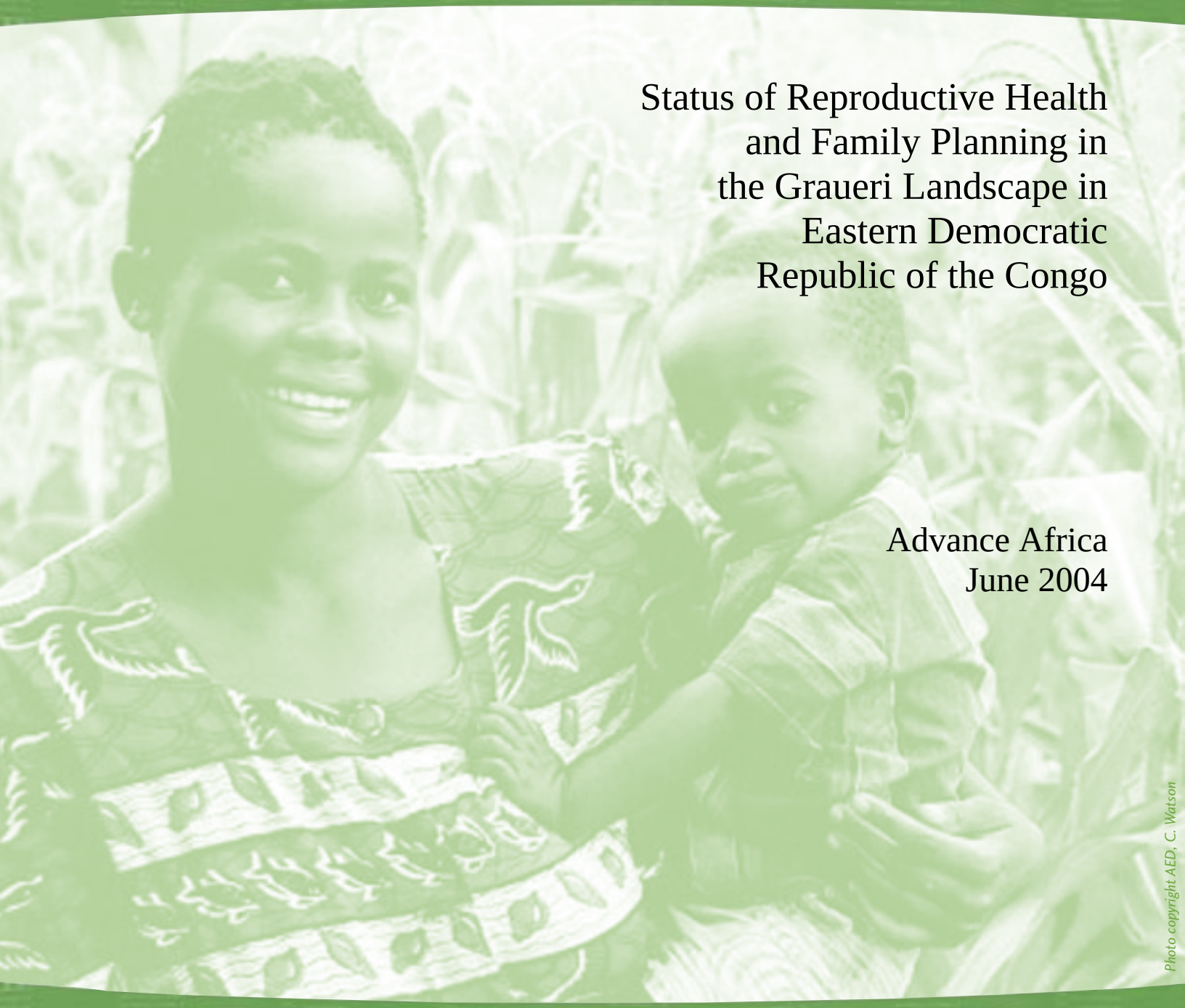

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SUMMARY

In the Democratic Republic of the Congo (DRC), contraceptive prevalence is low. According to the Multiple Indicator Clusters Survey (MICS2), it is estimated at 4.6% for the entire national territory. According to a recent study conducted by the nongovernmental organization Association Régionale d'Approvisionnement en Médicaments Essentiels (ASRAMES [Essential Medications Regional Supply Association]) in May 2003, the percentage is even lower—2.5%—in the eastern part of the DRC.

This situation necessitates support for family planning services. In response, Advance Africa proposed to conduct a study in the tenth ecological corridor, or Graueri Landscape, to obtain information that will assist in establishing a program that meets the community's needs. This program will be one component of a wider nature conservation program in collaboration with the Jane Goodall Institute.

A qualitative study using interview, focus group, and direct observation techniques was performed at three sites: Kasugho (Tayna gorilla reserve), Walikale (Utundu and Wassa gorilla reserve), and Butembo (location of the Tayna Gorilla Reserve [TGR] and Maiko Park offices). The results of the study were complemented with literature review.

- Interviews involved political administrative officials, community leaders and officials from the nongovernmental organizations (NGOs)
- Focus group sessions involved service providers and the beneficiaries
- The direct observation involved care facilities
- Documentation was reviewed at the Provincial Reproductive Health Coordination Office, Central Offices of the Health Zones, and with national and international NGOs

Issues concerning access, demand, quality, and sustainability were addressed by leaders, providers, and beneficiaries, which confirmed the urgent need for functional family planning services in the sites identified. Currently, there are no functional family planning services operating in these areas. Administrative political authorities are in favor of supporting family planning services in the area.

It is important to provide prenatal care services and clean facilities in all health centers to build a strong foundation for family planning. Community organizations are also valuable because they allow all members of the population to be served through community-based distribution. The reproductive health data collected at the different sites make it possible to evaluate the process and impact of the program.

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I. CONTEXT AND JUSTIFICATION

1.1. Context

Global biodiversity, covering only six percent of our planet's surface, is diminishing at an alarming rate. Tropical forests contain 90% of the biodiversity on the geographical globe.

The depletion of biodiversity takes a heavy toll on both nature and the global economy, weakening the living conditions of current and future generations. Forests are now disappearing at a rate of 14 million hectares per year (FAO, 2001) and the extinction rate of indigenous species continues to accelerate proportionately. Few countries can endure the transformation of over 10%-20% of their forests into completely protected zones.

Consequently, many contiguous forests outside the protected zones are situated to sustain the biodiversity of the forests and the dependent populations. Measures to ensure non-consumptive utilization and sustainable management of the forests' vestiges are crucial for the development of Central Africa and the ecological balance of our entire planet.

Several factors, such as the increase in expanses of arable land and the sale of small game, have influenced the loss of biodiversity. The large-scale expansion of commercial industries continuously devastate forests in Central and Eastern Africa. The establishment of residential areas in previously uninhabited forest zones and the growing urban demand for small game threaten to propel several species into extinction.

Impoverished local communities driven to rely on these limited resources are one of the biggest factors causing the irreversible depletion of the surrounding forests. The poorest populations directly depend on forests for their survival, and are deeply affected by the deterioration of the environment. Furthermore, it is difficult for these populations to adapt and take it upon themselves to recuperate forests because they are minimally protected by the social system that provides education, health services, and relief programs.

Consequently, community-centered conservation sites in Central Africa will use an approach that preserves biodiversity, while also protecting indigenous populations. While the primary objective is conservation, it is often necessary to tackle other issues not directly related to nature conservation, such as providing health services with the goal of gaining the trust and cooperation of local communities.

This study is part of a larger assessment to be undertaken by the nature conservation program headed by JGI. It focuses on the link between reproductive health and conservation in the aforementioned susceptible zones.

1.2. Justification

In Africa, and the DRC in particular, birth spacing has been customarily achieved through traditional methods (such as sleeping in separate beds), but in modern times, these methods are less practiced. Because modern contraceptive methods are more efficient and present fewer constraints, they are a more effective solution.

To address the growing need for family planning services, the DRC created the Desirable Birth Services Project (DBSP) in 1982. This project officially introduced modern contraceptive methods, and in conjunction with the Family Welfare Association, carried out the popularization of these methods in communities.

For nearly 10 years the DBSP, receiving financial support from USAID and the United Nations Population Fund, successfully introduced these methods to all large urban centers. With the break in bilateral cooperation due to civil instability, contraceptive prevalence, which was 14% in 1992, fell to 4.6% nationally and 8.8% in Kinshasa in 2002 according to the last MICS2 study. The survey also found high maternal mortality rates (1,837 maternal deaths per 100,000 inhabitants for the entire country, and 3,000 deaths per 100,000 inhabitants in the eastern part of the DRC) and high infant mortality rates (127 per 1,000 live births). A May 2003 study conducted by ASRAMES, entitled "Socioeconomic Study of the Households of the Nord-Kivu Province's Access to Care" shows that the use of modern contraceptive methods (injection, pill, intrauterine device [IUD], tubal ligation, implant) in the Nord-Kivu province is 2.3%.

Since 2003, family planning activities have been integrated into the Goma health zone with the financial support of two NGOs: Medical Emergency Relief International (MERLIN) and the Department of Community Services (DoCS). The 2003 annual report on the Goma Health Zone shows a contraceptive prevalence of 5.8% in the city of Goma.

This study clarifies some initial questions regarding the access, demand, service quality, continuation, and permanence of family planning services in the Graueri Landscape. It also helps determine opportunities and obstacles to establishing a family planning program in similar areas.

In order to establish a culturally sensitive program responsive to the expectations and demands of the affected populations, it is important to report on the perceptions, reactions, and ensuing practices of individuals regarding modern family planning methods. These reports will in turn be used as guides for the project. In addition, the collected data will be used to develop effective communication and marketing strategies (preparation of appropriate messages and media for Information, Education, and Communication [IEC]) promoting contraceptive products, tools, and services. The study will also reveal providers' training needs.

The study is comprised of three parts:

- Data review (documentation)
- Interviews with decision makers and association leaders; focus group sessions with beneficiaries and service providers
- Observation of the infrastructure, equipment, and functioning of services

II. OBJECTIVES OF THE STUDY

The primary objective of the study is to evaluate the family planning/reproductive health (FP/RH) situation in the Kahuzi-Biega conservation zone.

This study is particularly concerned with the following items:

- Access of FP/RH services with consideration for spatial distribution and social and cultural barriers, such as gender and class (financial resources)
- Identification of FP/RH services, noting the type, location, and time of the services' introduction to the area
- Quality of FP/RH services based on reports on training, exchange of experiences, and number of staff trained
- Demand for FP/RH services to determine the magnitude of the program
- Sustainability of services

III. METHODOLOGY

3.1. Selection of Sites

Advance Africa and the Jane Goodall Institute (JGI) carefully selected four sites to apply the project. These sites are located adjacent to gorilla protection branches.

These sites are:

- Kasugho: Area surrounding the Tayna gorilla reserve (TGR)
- Walikale: Area surrounding the Wassa (Regouwa) and Utundu gorilla reserve
- Pinga: Area surrounding the Bakana gorilla reserve

3.2. Targets

The study targeted health institutions that serve the entire population living around the protected reserves. Direct observation was carried out in the health facilities of Kasugho, Walikale, and Butembo. The Pinga visit was postponed due to pockets of instability, but information on FP/RH was collected from activity reports from the Pinga health zone.

The interviews targeted political-administrative officials, officials from primary and secondary educational institutions, health officials, churches, and officials of local associations. Thirty-five officials in total were questioned, 13 in Walikale, 10 in Kasugho, six in Butembo, and six in Goma.

Seven focus group discussions were conducted, each including 10 participants. Three of these groups concerned respective service providers in Kasugho, Butembo, and Walikale. Participants were from areas surrounding the Kasugho and Walikale health centers. Each focus group included 10 participants selected randomly with consideration for ethnic heterogeneity, age, and marital status.

Women of childbearing age (15 to 49 years) and men of working age (20 to 60 years) were chosen for the group.

Interviews with officials, such as the Chief of Staff of the health zone, the supervising physician, and registered nurses were conducted prior to the focus group sessions.

Staff members prepared the focus groups by explaining the exercises before the session and a group secretary was designated to document responses, which were summarized at the end of the session.

3.3. Collection of Data

Data was collected as follows:

- Direct Observation of the Health Institutions:

  Nine care facilities were visited: three in Kasugho, four in Walikale, and two in Butembo.

- Interviews and Focus Group:

SITES	INTERVIEWS	FOCUS GROUP
Kasugho	15	3
Butembo	8	1
Walikale	12	3
TOTAL	35	7

- Literature Review:

This phase represented one of the most important steps in the collection of the data. Much of the information was gathered from the Provincial Health Division, existing nongovernmental organizations, health zone reports, provincial health coordination offices, and previous surveys.

IV. DESCRIPTION OF THE SITES

4.1. Tayna Gorilla Reserve Site in Kasugho

4.1.1. Geographic Data

The Tayna Gorilla Reserve is located in the northeast section of the Nord-Kivu province. Its climate is common to that of mountainous regions (hot at low altitudes and temperate at high altitudes). The relief is surrounded by a chain of mountains that emerge from the coastline of Edouard Lake. High, temperate-climate plateaus extend over the mountains.

4.1.2. Economic Data

The population's principal activities are agriculture, fishing, petty trade, and gold mining. The population's sources of income are agriculture, fishing, and informal trade.

4.1.3. Demographic Data

In 2002, the total Kasugho population was 3,761 while the health area population was 24,840*. Kasugho is a health center in the Lubero health zone, which has a population of 263,096* with the following demographic breakdown:

0 – 11 months = 10,524
0 – 59 months = 52,619
12 – 59 months = 5,262
5 – 15 years = 121,024
Women of childbearing age = 55,250
Expected pregnancies per year = 10,523
Density = 78 inhabitants/km^2

4.1.4. Existing Social Structures

The area possesses several churches, educational institutions, health services institutions (hospitals, primary care facilities, health centers), and community organizations (TGR, etc.).

4.1.5. Health Problems

Predominant health problems in the region are malaria, acute respiratory infections, non-choleriform gastroenteritis (non-bloody diarrhea), anemia, malnutrition, and meningitis. Malaria, acute respiratory infections, non-choleriform gastroenteritis, and anemia are extremely lethal to inhabitants.

* This data was taken from the annual report on the Lubero Health Zone. It was collected during the census conducted on national vaccination days.

Table 1. Epidemiological Surveillance in the Tayna Gorilla Reserve in 2003

Health Problems	**NC < 5 years**		**NC > 5 years**		**Total**	
	NC	**Deaths**	**NC**	**Deaths**	**NC**	**Deaths**
Amoebiasis	479	0	1934	0	2413	0
Anemia	656	16	1620	17	2276	33
Burns	189	1	115	0	304	1
Conjunctivitis	1521	0	1017	0	2538	0
Pertussis	8	0	2	0	10	0
Non-bloody Diarrhea	4437	20	2299	31	6736	51
Bloody Diarrhea	92	1	150	5	242	6
Gastritis	0	0	2965	3	2965	3
Skin Infections	1539	0	1899	0	3438	0
Ear, Nose, Throat Infections	1001	0	1651	0	2652	0
Acute Respiratory Tract Infections	12560	48	7299	12	19859	60
Malnutrition	320	11	142	5	462	16
Meningitis	39	2	49	8	88	10
Malaria	7707	38	15818	51	23525	89
Clinical AIDS	1	1	322	2	323	3
Traumatism	783	0	2960	1	3743	1
Tuberculosis	0	0	11	1	11	1
Verminous conditions	4003	0	6292	0	10295	0
TOTAL	**35335**	**138**	**46545**	**136**	**81880**	**274**

Source: Lubero Health Zone 2003 Annual Report.

4.1.6. Reproductive Health Data

Prenatal Care
The table below shows the general status of each health center in the Lubero health zone in 2003.

Table 2. Prenatal Care

No.	Structures	Pop./year	New Cases*				Usage Rates
			AS	HA	HZ	TOTAL	
1	Kirikiri	345	317	108	2	427	92%
2	Kisima	228	189	89	2	280	83%
3	Kitsombiro	551	436	184	26	646	79%
4	Masereka	666	540	102	46	688	81%
5	Baraka	435	318	109	6	433	73%
6	Bukununu	437	487	113	15	615	111%
7	Kaghuli	490	383	3	0	386	78%
8	Kalimba	547	417	7	1	425	76%
9	Kasalala	537	346	171	25	542	64%
10	Kasima	468	467	58	6	531	99.7%
11	Kasugho	994	323	0	3	326	32%
12	Katolo	238	242	10	4	256	101.6%
13	Kipese	531	487	252	10	749	98%
14	Kitsimba	693	518	144	5	667	75%
15	Lubango	586	477	60	43	580	81%
16	Lubero	608	377	179	7	563	62%
17	Muringate	292	279	0	1	280	95%
18	Mulo	531	304	0	0	304	57%
19	Mubana	371	343	50	33	426	92%
20	Vukendo	340	259	2	0	261	76%
21	Vunyakondomi	390	283	21	0	304	72%
22	Ndoluma	246	129	2	4	135	52%
	TOTAL	**10524**	**7921**	**1664**	**239**	**9824**	**92%**

*AS=within area; HA=outside health area; HZ=outside health zone.
Source: Lubero Health Zone 2003 Annual Report.

Table 3. Supervised Deliveries

No.	Structures	Target Population	Number of Births*			
			AS	HA	HZ	TOTAL
1	General Hospital for Referrals	-	567	-	-	567
2	Kirikiri	345	235	182	12	429**
3	Kisima	228	252	430	9	691**
4	Kitsombiro	551	498	212	151	861**
5	Masereka	666	778	445	71	1294**
6	Baraka	435	271	102	4	377
7	Bukununu	437	521	171	5	697**
8	Kaghuli	490	195	0	0	195
9	Kalimba	547	220	4	1	225
10	Kasalala	537	249	136	3	388
11	Kasima	468	370	20	4	394
12	Kasugho	994	174	0	3	177
13	Katolo	238	219	39	11	269**
14	Kipese	531	458	262	13	733**
15	Kitsimba	693	482	102	2	586
16	Lubango	586	285	20	20	325
17	Lubero	608	372	144	11	527
18	Muringate	292	256	1	10	267
19	Mulo	531	307	1	2	310
20	Mubana	371	169	27	2	198
21	Vukendo	340	164	8	0	172
22	Vunyakondomi	390	200	25	0	225
23	Ndoluma	246	76	10	4	90
TOTAL		**10524**	**7318**	**2341**	**338**	**9997**

*AS=within area; HA=outside health area; HZ=outside health zone.
** Many births occurred among women not living in the health areas of the Lubero health zone.
Source: Lubero Health Zone 2003 Annual Report.

Vaccination Data

The following data records vaccinations of pregnant women in the Lubero health zone in 2003:

- PNC target population: 2,790
- Vaccinated population: 1,659
- Percentage: 51%

Source: Busise annual review of the 2003 health information system

Table 4. Live Births, Birth Weights, and Utilization Rates

No.	Structures	Target Population	Total Births	Live Births	Weight <2.5kg	Utilization Rates
1	HGR	-	570	550	84	-
2	Kirikiri	345	430	425	24	68
3	Kisima	228	703	684	97	110*
4	Kitsombiro	551	865	852	127	90
5	Masareka	666	1304	1285	123	116
6	Baraka	435	377	375	19	62
7	Bukununu	437	703	692	84	119*
8	Kaghuli	490	198	193	19	40
9	Kalimba	547	225	221	26	40
10	Kasalala	537	389	389	46	46
11	Kasima	468	399	399	52	79
12	Kasugho	994	181	170	34	17
13	Katolo	238	269	266	22	92
14	Kipese	531	741	725	64	86
15	Kitsimba	693	587	587	68	69
16	Lubango	586	330	324	86	48.6
17	Lubero	608	537	533	102	61
18	Muringate	292	268	264	17	87.6
19	Mulo	531	310	306	11	57.8
20	Mubana	371	198	194	14	45
21	Vukendo	340	175	170	14	48
22	Vunyakondomi	390	225	209	14	51
23	Ndoluma	246	90	90	4	31
Total		10524	10903	9903	1151	92

* Utilization of health centers by non-inhabitants of the concerned health areas have accelerated the depletion of resources.
Source: Lubero Health Zone 2003 Annual Report

4.2. WASSA Gorilla Reserve Sites in Walikale

4.2.1. Geographic Data

Located in the Walikale territory, the Wassa gorilla reserve has an equatorial climate characterized by two seasons, the rainy season from March through May and September through December, and the dry season from January through February and June through August.

Its relief is characterized by uneven plateaus and its surface is 13,600 km². Tropical rainforests make up the dominant vegetation. The principal arteries of travel are the airfield and roads.

4.2.2. Economic Data

The population is involved in agriculture, traditional mining (gold, cassiterite, diamonds, etc.), livestock farming, and traditional fishing. The population's primary source of revenue however is traditional mining and informal trade.

4.2.3. Demographic Data*

Total population : 98,596

- 0-11 months: 3,944
- 0-5 years: 19,719
- Women of childbearing age: 20,705
- Household size: 8
- Density: 7/km²

4.2.4. Existing Social Structures

The area possesses religious institutions, primary and secondary schools, universities, health services institutions (hospitals, health centers, health posts, pharmacies), community organizations, and NGOs.

4.2.5. Health Situation

4.2.5.a. Health Coverage
Number of hospitals: 1
Number of health centers in operation: 23
Number of health posts: 51

The general hospital includes gynecological obstetrics, internal medicine, and surgical departments. The health centers practice curative and preventative medicine.

4.2.5.b. Principal Health Problems
The following are the principal causes of morbidity and mortality in Walikale:

- Malaria: 34.7%
- Anemia: 19%
- Acute Respiratory Infections: 22%
- Gastroenteritis: 12.2%

* Census of the population by Health Zone in 2002 for the national vaccination days..

Table 5. Epidemiological Surveillance: Principal Health Problems

PROBLEMS	New Cases		Deaths	
	- 5 YEARS	+ 5 YEARS	- 5 YEARS	+ 5 YEARS
Malaria	7772	8750	26	6
Worm Infestation	2717	337	0	0
Anemia	700	17	21	1
Acute Respiratory Tract Infections	140	1450	21	2
Bloody Diarrhea	407	404	33	2
Non-bloody Diarrhea	311	195	4	0
Malnutrition	807	10	21	1
Measles	62	35	3	1

Source: Walikale Health Zone 2003 Annual Report

4.2.5.c. Reproductive Health Data

Supervised Deliveries

In 2003, a total of 1,447 supervised deliveries took place in the Walikale health centers and 177 in the Walikale general hospital.

Table 6: Distribution of Attended Deliveries in the Walikale Health Zone

No.	Health Area	Attended Delivery	Total Births	Maternal Deaths
1	Bilobilo	228	210	3
2	Buruwe	164	60	0
3	Byungu	198	72	0
4	ElibaLIBA	138	103	3
5	Ibanga	148	49	0
6	Idipo	143	39	0
7	Itebero	155	36	0
8	Kabamba	64	17	0
9	Karete	138	41	0
10	Lubonga	103	30	1
11	Malembe	177	42	0
12	MpofiI	48	0	0
13	Mundindi	161	89	0
14	Musenge	237	84	0
15	Mutakato	415	89	0
16	Ndjingala	161	44	0
17	Ndofia	111	82	0
18	Ntoto	111	13	0
19	Nyasi	180	68	0
20	Obaye	156	12	0
21	Otobora	114	52	0
22	Sacre-Coeur	384	86	0
23	Walikale	157	81	0
TOTAL		**3944**	**1447**	**7**

Source: Lubero Health Zone 2003 Annual Report

The percentage of births occurring in health centers is 36.6%. This indicates that the majority of births do not take place in health facilities, but in villages under the supervision of traditional birth attendants.

Vaccination Data

The following data records vaccinations of pregnant women in the Walikale health zone in 2003:

- PNC target population: 2,790
- Vaccinated population: 1,659
- Percentage: 51%

Source: Busise annual review of the 2003 health information system.

Prenatal Care (PNC)

The PNC coverage was 60% in 2003. This coverage was distributed by health area as follows:

Table 7: PNC Coverage Rate by Health Area

No.	Health Areas	Target Population - Pregnant Women	New Cases		Coverage in 2003
			AS / 2003	HA / 2003	
1	Bilobilo	228	271	16	118%
2	Buruwe	164	212	01	129%
3	Byungu	198	180	12	91%
4	Eliba	138	144	27	104%
5	Ibanga	148	56	2	37.8%
6	Idipo	143	34	9	23%
7	Itebero	155	72	4	46%
8	Kabamba	64	34	0	53%
9	Karete	138	91	8	66%
10	Lubonga	103	58	0	56%
11	Malembe	177	73	9	41%
12	Mpofi	97	77	1	79%
13	Mundundi	161	123	0	76%
14	Musenge	237	154	26	65%
15	Mutakato	415	110	6	26.5%
16	Ndjingala	161	64	2	40%
17	Ndofia	111	99	19	89%
18	Ntoto	111	42	0	38%
19	Nyasi	180	108	9	60%
20	Obaye	156	14	0	9%
21	Octobora	114	105	19	92%
22	Sacre-Coeur	387	77	17	20%
23	Walikale	157	176	31	112%
TOTAL		**3944**	**2371**	**218**	**60%**

*AS=within area; HA=outside health area.

4.3. Butembo Site

Both the TGR and the Congolese Institute for the Conservation of Nature is located in Butembo, which is within the Butembo health zone. It was thus appropriate to conduct research in this city, which is described in detail below.

4.3.1. Geographic Data

Butembo is located in the northeastern part of the DRC. It is the county town of the territory of the same name, and is situated between the Lubero and Beni territories.

Butembo is covered by scattered mountains and traversed by large rivers. It has an equatorial climate, but also experiences abundant rainfall from its mountains. The principal arteries of travel are the airfield and roads.

4.3.2. Economic Data

The population's primary activity is agriculture, livestock farming, and trade.

4.3.3. Demographic Data*

The population of the Butembo health zone is estimated at 272,749 inhabitants (2002 estimate) with a birthrate of 4.8%. The population density is roughly 287 inhabitants per km².

Population Data:

- 0 – 1 years : 10,940
- 1 – 4 years : 43,640
- Women of childbearing age: 57,277

4.3.4. Health Data

4.3.4.a. Health Coverage

* Data taken from the 2003 Butembo health zone annual report.

The Butembo rural health zone is covered by one general hospital, 21 health centers, and about 10 commercial first-aid posts owned by private individuals. There are also three hospital centers, three reference health centers, and several pharmacies owned by private parties.

4.3.4.b. Principal Health Problems

The primary health problems of the Butembo Health Zone are malaria, worm infestation, acute respiratory infections, diarrheal diseases, malnutrition, anemia, STDs, and HIV.

4.3.4.c. Reproductive Health Data[*]

Prenatal Care Coverage:	82%
Target Population:	10,910
New Cases:	8,931

Attended Deliveries	
Expected Births:	13,040
Deliveries:	5,950
PNC Target Population:	1,754
Vaccinated Population:	980 (29.8%)

Source: BUSISE annual review of the 2003 health information system.

4.4. Pinga Site

Although it was scheduled on our agenda, it was difficult for us to reach this site because of pockets of insecurity. However, health problems are similar to the other areas reviewed.

See attached map.

[*] Annual report for the health zone.

V. RESULTS

5.1. Results of the Focus Groups and Interviews

5.1.1. Sociodemographic Characteristics

We conducted seven focus group discussions and interviewed 35 people comprised of community leaders, administrative officials, and association members. Our sample units were comprised of a total of 105 people, comprised of 56 women and 49 men.

5.1.1.a Distribution of Participants According to Age and Gender

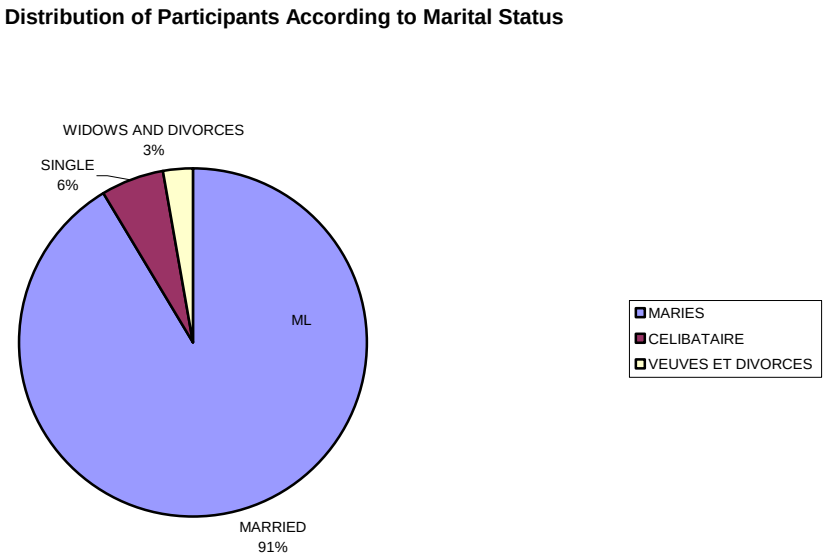
Table 8: Distribution of Participants According to Age Group

AGE GROUP	FREQUENCY	PERCENTAGE
15 – 19	4	3.8%
20 – 24	11	10%
25 – 29	18	17%
30 – 34	17	16%
35 – 39	25	23%
40 – 44	10	9%
45 – 49	12	11%
50 and older	8	7%
TOTAL		100%

As one can see, the table above shows the largest proportion of participants in the 35 to 39 year old age group.

5.1.1.b. Distribution of Participants According to Marital Status

Table 9: Distribution of Participants According to Marital Status



[Chart legend: Maries = Married, Celibataire = Unmarried, Veuves et Divorces = Widows and Divorcés]

Of the 105 people interviewed, 91% were married, 5.7% were unmarried, and 2.8% were widows or divorcés.

5.1.1.c. Distribution of Participants According to Education Level

Sixty-five percent of the participants had a secondary-level education, 17% had a primary-level education, and 11% had a university education. Seven percent had no education.

The interviews and focus groups targeted community leaders, health care providers, and a small number of representatives from the predominantly illiterate population. This limited the results of the survey.

5.1.1.d. Distribution of Participants According to Profession

Of all respondents, 37% were administrative officials and officials of NGOs and health institutions, 25% were farmers, peasants, and miners, 26% were health care professionals, 10% were self-employed (shopkeepers), and 2% were students.

5.1.1.e. Distribution According to Religious Affiliation

Of all respondents, 42% were Protestants, 39% were Catholics, and 15% represented other denominations (Eglise de Réveil, Muslims, Jehovah's Witnesses, and others). Four percent had no religious affiliation.

5.1.2. Opinions of the Leaders

A total of 35 representatives from the community participated in interviews. This group was comprised of officials of NGOs and local associations, political-administrative officials, medical officials, church officials, and school officials.

All relevant health issues were addressed to aid in the development of the project's scope of work.

5.1.2.a. Access to Services

To better understand community leaders' overall response to family planning services they were asked two open-ended questions:

1) When we talk about family planning, what do you think of?

Responses were comprised of the following:

- Thirty-five percent admitted they know nothing about the issue
- Thirty percent believed family planning simply meant planned births
- The last 35% was comprised of several responses, some of which were:
  -It is a strategy to regulate births in the national reproductive health program
  -It is a program integrated into the health zone
  -It is a way to make couples be faithful
  -It is a problematic practice, forbidden by the church
  -It is a strategy that minimizes birth-related health risks by spacing births
  -It is a method of organizing families

2) What is birth spacing?

Responses were comprised of the following:

- It is the use of contraceptive methods: 50%
- It is having children when desired: 20%
- It is the introduction of native products into the vagina to avoid pregnancy: 5%
- It is an evil recommendation formally prohibited by the church, as children are a gift from God: 5%
- It is ending the marital bed for a period: 10%
- No answer: 10%

5.1.2.b. Service Demand

Two questions were posed to opinion leaders regarding the demand for services.

1) Do you know where women can find FP/RH services?

Eighty percent of respondents declared that their area has no place where women can resolve family planning issues, though some doctors revealed there are rare cases of tubal ligation in hospitals for therapeutic purposes.

2) Who can help women with FP/RH issues?

Respondents gave three answers to this question: doctors, nurses, and midwives.

5.1.2.c. Service Quality

Two questions were asked with regard to service quality:

1) What factors prevent women of childbearing age from obtaining services?

Because services in this area are currently nonexistent, respondents suggested various factors that can impede the proper functioning of family planning services once they have been established. The following responses were given:

- War
- Lack of information
- Lack of equipment and appropriate products
- Lack of trained and qualified staff
- Religion
- Tradition

2) What conditions would make a center providing FP/RH services most accessible to women?

The majority of responses converged on the following conditions:

- competence of service providers
- cleanliness of the premises
- low cost of products
- good facilities

5.1.2.d. Sustainability of Service

Participant answers to the following question verified the need for family planning services in the area.

Two questions about the sustainability of services were posed to community leaders:

1) Are these services free? Do you know how much it costs?

The majority of respondents hoped to receive services for a relatively low price. A considerable proportion wanted free services.

2) In your opinion, what can be done to improve FP/RH services?

Respondents unanimously agreed that these services must first be integrated into the minimum primary health care package of the region and that they should be accessible to everyone.

On this subject, three proposals were made:

1. Provide kits to community-based distributors in order to reach the entire population (proposed by the majority).
2. Revitalize existing health centers in order to integrate family planning.
3. Rely on community care facilities to raise the community's awareness about family planning services.

5.1.3. Health Care Providers

Over 30 health care providers responded to our questionnaire in Kasugho, Butembo, and Walikale. Information was collected regarding the access, demand, quality, and sustainability of services. Our questionnaire first addressed the general characteristics of health problems and the organization of various services.

5.1.3.a. Access to the Service

Two questions were posed to determine what providers think about access to the service:

1) How do you explain the fact that only a small number of women use family planning services?

This question was answered by over 70% of the respondents, the majority of which responded that family planning concerns couples. However, adolescents can use condoms to protect themselves against sexually transmitted diseases and HIV/AIDS.

2) What do you think about men using family planning services?

The majority of the respondents believed that family planning is predominantly a male issue because it is the male's decision whether to use this service with his wife. Males must also use condoms to be protected from STDs and HIV/AIDS.

5.1.3.b. Service Demand

It is important to determine health care providers' perspectives on family planning services.
Two questions were posed on this subject:

1.Have you ever heard of family planning services?

All providers responded that they learned what family planning was in school.

2.Do you have any thoughts on the function of FP/RH services?

Fifty percent responded that they do not know why this service is not in operation.

The remaining 50% listed the following reasons:

- lack of knowledge of this service
- lack of appropriate materials and input
- lack of partners to support this activity

5.1.3.c. Service Quality

This section concerns providers' opinions on the quality of family planning services.

1) Can you say something about the quality of family planning services at your respective health center?

Respondents could not say anything about the quality of these services because they do not know how it works. Nevertheless, some desired qualities were cited, including:

- Welcoming staff
- Presence of medication and appropriate equipment
- Qualified and competent staff
- Motivated staff

2) Can you tell us about the difficulties you've encountered as a provider of family planning services?

We do not have any difficulties to report because these services do not exist in our area.

3) As a health care provider, tell me what you think about the use of contraceptive methods?

Sometimes, condoms are used because they are sold in pharmacies. Other methods (injections, pills, IUDs, etc.) may be used with good awareness.

4) What would be the role of the government, community, and the beneficiary?

The majority of respondents answered with the following:

- The government must take appropriate steps in providing quality health care to the people.
- The community must organize to protect its interests and benefits relative to its health and social conditions.

- Beneficiaries must contribute somewhat to the operation of the service to ensure its sustainability.

5.1.4. Beneficiaries

Forty people, comprised of 20 women and 20 men, participated in various focus groups. Of these 40 people, 18 women and 18 men were married, leaving two women and two men unmarried.

Information obtained from leaders and providers concerned access, demand, quality, and sustainability. Before going in depth, some general questions were first addressed.

5.1.4.a. Access to Services

Three questions were asked in this section:

1) How do you explain the small number of women who use family planning services?

Table 10: Reason for the Low Female Use of Family Planning Services

GROUP OF PARTICIPANTS	REASONS STATED
Married Women	Lack of information Service does not exist Only God can plan births
Married Men	Lack of information Women are afraid of the negative consequences of contraception.
Unmarried Women	Lack of information
Unmarried Men	Lack of information

2) What do you think about adolescents using family planning services?

Table 11: Adolescent Use of Family Planning Services

GROUPS OF PARTICIPANTS	DIFFERENT POINTS OF VIEW
Married Women	Family planning services are not for adolescents.
Married Men	Adolescents are not concerned with spacing births. Adolescents are not permitted to have children outside marriage.
Unmarried Women	Adolescents are also concerned about preventing early pregnancy and STDs.
Unmarried Men	Adolescents would benefit from this service because young girls are often victims of rape. Adolescents must protect themselves against sexually transmitted diseases by using condoms.

According to these responses, unmarried people and adolescents are interested in using family planning services, while married people see family planning as a married couple's issue.

3) What do you think about men using family planning services?

Table 12: Male Use of Family Planning Services

GROUPS OF PARTICIPANTS	OPINIONS OF EACH GROUP
Married Women	It is mandatory for men to use family planning services because they are the ones who make the household decisions.
Married Men	Men must use condoms to protect themselves against STDs and HIV/AIDS and to prevent unwanted pregnancies.
Unmarried Women	Men must direct their wives to family planning services.
Unmarried Men	Men must also use family planning services.

All groups believed men should be completely involved in family planning.

5.1.4.b. Service Demand

Two questions were posed to learn whether there is a demand for family planning services.

1) Have you heard about family planning services?

Table 13: Knowledge of Family Planning Services

GROUPS OF PARTICIPANTS	KNOWLEDGE OF FP SERVICES
Married Women	They have heard of family planning services.
Married Men	They have already heard about planned births.
Unmarried Women	They have not yet heard of planned birth services.
Unmarried Men	They have not yet heard of planned birth services.

The table shows that only married people know or have heard of the existence of family planning services.

2) Do you have any thoughts on its function?

The majority of respondents did not answer this question. However some did remark that health professionals are the ones who should answer this question.

5.1.4.c. Service Quality

To learn what beneficiaries think about the characteristics of quality family planning services, they were asked two questions, one relative to service quality and the other on the difficulties they encounter.

1) Can you say something about the quality of family planning services?

Table 14: Service Quality

GROUPS OF PARTICIPANTS	OPINION ON SERVICE QUALITY
Married Women	Family planning services must have many products and a competent staff led by women.
Married Men	Family planning services must be well-equipped, clean, and possess many products.
Unmarried Women	Family planning services must be clean, run by women, and possess the appropriate products and equipment.
Unmarried Men	The service must have a competent staff.

Respondents noted the following qualities were necessary for good family planning services:

- Competent staff
- Products of good quality
- Good equipment
- Suitable infrastructure

2) Can you tell us about any difficulties you encounter when you use family planning services?

Due to the nonexistence of this service, we shaped the question to ask about possible obstacles for properly functioning family planning services.

Table 15: Obstacles to Family Planning Services

GROUPS OF PARTICIPANTS	OBSTACLES TO FAMILY PLANNING
Married Women	Negative rumors (cancer, risk of sterility) Tradition (authoritarianism of the husband) Catholicism Ignorance Indiscretion of providers
Married Men	Ignorance Religion Cost of products
Unmarried Women	No responses
Unmarried Men	Cost of the products

The table shows that negative rumors, religion, and ignorance are possible obstacles to the establishment of functioning family planning services in the area.

5.1.4.d. Sustainability of Service

The following questions were asked to determine the necessary factors for the sustainability of services:

1) What is your opinion on the use of contraceptive methods?

Table 16: Use of Contraceptive Methods

GROUPS OF PARTICIPANTS	OPINION OF EACH GROUP
Married Women	- We must use them to space out births and be healthy: 50% - We must not use them because we need children: 20% - We must not use them because religion forbids it: 10% - It has negative consequences (cancer, sterility): 20%
Married Men	- These methods are necessary for the health of the mother and children: 60% - Children are gifts from God and we cannot stop them from coming into the world: 20% - No response: 20%
Unmarried Women	No response
Unmarried Men	No response

Over 60% of the respondents think that using contraceptive methods will contribute to improving the health of mothers and children. However, others believe that children come from God and that planning births is against their religion.

2) What should be the role of the government, community, and beneficiaries in family planning services?

Table 17: Role of the Government, Community, and Beneficiaries

GROUPS OF PARTICIPANTS	OBSTACLES TO FAMILY PLANNING
Married Women Married Men Unmarried Women Unmarried Men	- The government must find solutions to all of our health problems. - The community must organize to take control of and protect its interests. - Beneficiaries must contribute to the function of the service to ensure its sustainability.

All categories of respondents made recommendations summarized in the table above .

5.2. Observation of Service Facilities

Nine service facilities underwent direct observation. Attention was centered on external and internal aspects.

Table 18: Overview of Facilities and Services

No	Facilities	Ownership	Condition of the Building	Physician Present		Nurses Present		Existence of a Maternity Ward
1	Reference General Hospital/Walikale	Government	Clean	Yes	3	Yes	8	Yes
2	Sacré Cœur Health Center/Walikale	Private Nonprofit (Catholic Church)	Clean	No	--	Yes	2	No
3	8th CEPAC Health Center/Walikale	Private Nonprofit (Protestant Church)	Clean	Yes	1	Yes	6	Yes
4	TGR. Medical Center/Kasugho	Non-profit Community	Clean	No	--	Yes	8	No
5	CBKA Center/ Kasugho	Private Nonprofit (CBKA Protestant Church)	Clean	No	--	Yes	4	Yes
6	Kasugho Community Health post	Government	Clean	No	--	Yes	2	Yes
7	Mama Masayi Health Center/Butembo	Government	Clean	Yes	2	Yes	10	Yes
8	CBKA Health Center/Butembo	Private Nonprofit (Protestant Church)	Clean	Yes	1	Yes	9	Yes

Table 19: Overview of Equipment and Services

No.	Facilities	Physician Trained in FP	Nurse Trained in FP	FP Service In Operation	Pharmacy at the Center	IEC Material	Laboratory at the Center
1	Reference General Hospital/Walikale	No	No	No	Yes	No	Yes
2	Sacré Cœur Health Center/Walikale	No	No	No	Yes	No	Yes
3	CEPAC 8th Health Center/Walikale	No	No	No	Yes	No	No
4	T.G.R. Medical Center/Kasugho	No	No	No	Yes	No	No
5	CBKA Center/Kasugho	No	No	No	Yes	No	Yes
6	Kasugho Community Health post	No	No	No	Yes	No	Yes
7	Masayi Mama Health Center/Butembo	Yes	No	No	Yes	No	Yes
8	CBKA Health Center/Butembo	No	No	No	Yes	No	Yes

The table above shows that only one physician was trained in family planning at the Masayi Mama Health Center in Butembo. No nurses were trained.

In addition, family planning services are not available everywhere and IEC equipment does not even exist.

All facilities have at least one internal pharmacy and one medical laboratory. These laboratories are not well-equipped and use outdated equipment.

Table 20: Electricity, Drinking Water, and Lighting

No.	Facilities	Electricity	Drinking Water	Lighting	Ventilation
	Reference General Hospital/Walikale	Yes	Yes	Yes	No
	Sacré Cœur Health Center/Walikale	No	Yes	Yes	No
	CEPAC 8th Health Center/Walikale	Yes	Yes	Yes	No
	T.G.R. Medical Center/Kasugho	No	Yes	Yes	No
	CBKA Center/Kasugho	No	Yes	Yes	No
	Kasugho Community Health post	No	Yes	Yes	No
	Masayi Mama Health Center/Butembo	Yes	Yes	Yes	No
	CBKA Health Center/Butembo	Yes	Yes	Yes	No

There is no ventilation system because of the mountain climate. All facilities have drinking water while some health centers have electricity.

The following sites were observed: waiting room, examination room, laboratory, pharmacy, maternity ward, emergency room, and the general premises.

Table 21: Available Equipment

No.	Facilities	Examination Table	Instrument Case	Stethoscope	Pinard Stethoscope	Blood Bags	Antiseptics	Autoclave	Sterilizer	Toilets	Sterile Gloves
1	Reference General Hospital/Walikale	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes
2	Sacré Cœur Health Center/Walikale	No	No	Yes	No	No	Yes	No	No	Yes	Yes
3	CEPAC 8th Health Center/Walikale	Yes	No	No	No	No	Yes	Yes	Yes	Yes	Yes
4	T.G.R. Medical Center/Kasugho	No	No	No	No	No	No	No	No	Yes	No
5	CBKA Center/Kasugho	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes
6	Kasugho Community Health post	No	No	Yes	No	No	Yes	No	No	Yes	Yes
7	Masayi Mama Health Center/Butembo	Yes	Yes	Yes	No	No	No	No	No	Yes	No
8	CBKA Health Center/Butembo	Yes	Yes	Yes	Yes	Yes	Yes		No	Yes	Yes

VI. OBSTACLES AND OPPORTUNITIES

Several obstacles and opportunities for family planning services were listed during this study. They are both general and specific in nature.

OBSTACLES

- Pockets of insecurity
- Geographic inaccessibility
- Poverty of population
- High illiteracy rate
- Ignorance of family planning
- Lack of people trained in family planning
- Lack of family planning services and IEC counseling
- Resistance to family planning services because of religion
- Lack of community-based distributors
- Lack of postnatal (PoNC) care services

OPPORTUNITIES

- Predisposition to accept family planning services
- Presence of maternity wards
- Presence of PNC activities
- Presence of primary care staff
- Presence of adequate and clean infrastructure
- Presence of organized NGOs, ready to perform community-based distribution (CBD)
- Predisposition for contributing financially and sustaining the service
- Presence of a community awareness service for the the fight against HIV/AIDS

5.1. Noted Obstacles and Opportunities Organized by Group

Table 22: Obstacles and Opportunities

No.	GROUP OF RESPONDENTS	CONSTRAINTS	OPPORTUNITIES
1	Opinion Leaders	Inadequate knowledge of family planning	- Existing support in establishing family planning services - Community openness to support awareness through social mobilization
2	Providers	- Lack of in-depth knowledge of contraceptive methods - Staff not trained in family planning	- Existing support in establishing family planning services - Community open to supporting the use of family planning services through education during PNC
3	Beneficiaries	- Ignorance of family planning and modern contraceptive methods - High illiteracy rate - Fear of religious authorities for using family planning services	- Predisposition to accept family planning services - Predisposition to contribute financially for services - Predisposition to ensure CBD
4	Observers of the Care Facilities	- Lack of adequate equipment - Lack of staff trained in family planning - Lack of family planning services	- Clean infrastructure with water and electricity - Presence of maternity wards - Openness to receive family planning services.

CONCLUSION

This study succeeded in providing information on four critical areas: access, demand, quality, and sustainability of services. This information was collected from four sources: interviews with opinion leaders, focus groups with service providers and beneficiaries, documentation review, and direct observation of care facilities. Because family planning services were not yet in operation, we directed our research toward other aspects of reproductive health.

Obstacles to and opportunities for the establishment of family planning services were identified during this process. It was clear that the area was in need of family planning services and plans should be made to implement them. This would require the training of trainers, training of community-based distributors and community-based outreach volunteers, efforts to raise the awareness of the population, the purchase of community-based distributor kits and traditional birth attendants, and the revitalization of existing health facilities.

ANNEX 1

PRINCIPAL INFORMANT GUIDE (for opinion leaders)

- Familiarize yourself with the guide
- Think about the four areas where information is needed: access, demand, quality, and sustainability of services
- Draft a 30-minute interview for each of these areas

1. Can you describe your role in the community?
2. How would you generally describe the health of the children in your community?
3. Do you or your organization have any interest in or responsibility for health issues?
4. Can you tell us what you think the community's expectations for health services are, specifically with regard to HIV/AIDS treatment?
5. What do you think of when you hear the term "family planning"?
6. What do you know about birth spacing?
7. Do you know where young women can find help with reproductive health and family planning?
8. Who can help them?
9. What factors prevent women of childbearing age from using family planning services?
10. Do you know the conditions of this service, and whether they are accessible to young women?
11. Are these services free? Do you know the costs for these services?
12. In your opinion, what could be done to improve FP/RH services in your area?

ANNEX 2

FOCUS GROUP ORGANIZATION GUIDE (Providers)

I. Introduction and Goal

II. Discussion

GENERAL INFORMATION

- What is the general condition of health care equipment in your health center?
- What services are offered at your health center?
- Are these services easily accessed by the public? Why or why not?

FAMILY PLANNING/REPRODUCTIVE HEALTH SERVICES

ACCESS TO SERVICES

1) Why do you think few women in your community use family planning services?
2) What do you think about adolescents using FP/RH services?
3) What do you think about men using FP/RH services?

DEMAND

1) Have you ever heard about family planning services?
2) Do you know why reproductive health services are not available in your area?

SERVICE QUALITY

1) For those who work at health centers that offer FP/RH services, how would you describe the quality of these services?
2) Can you tell us about the difficulties you encounter as FP/RH health care providers?

SUSTAINABILITY

1) As a health care provider, what is your opinion on the use of contraceptive methods?
2) What role should the government, community, and beneficiaries play in sustaining these services?

III. Conclusion

Thanks and summary of what was said.

ANNEX 3

FOCUS GROUP ORGANIZATION GUIDE (Community)
I. Introduction and Goal
II. Discussion

GENERAL INFORMATION
Do you have any health problems? If so, what are they?

FAMILY PLANNING/REPRODUCTIVE HEALTH SERVICES

ACCESS TO SERVICES
1) Why do you think few women in your community use family planning services?
2) What do you think about adolescents using FP/RH services?
3) What do you think about men using FP/RH services?

DEMAND
1) Have you ever heard about family planning services?
2) Do you have any thoughts on their function?

SERVICE QUALITY
1) Can you describe the quality of a family planning services at your center?
2) Can you tell us about the difficulties you encounter as FP/RH health care providers ?

SUSTAINABILITY
1) What is your opinion on contraceptive methods?
2) What role should the government, community, and beneficiaries play in sustaining these services?

III. CONCLUSION

Thanks and summary of what was said.

ANNEX 4

OBSERVATION GUIDE (Overview of health care equipment)

Site:
Date:
Directed by:
Hours of operation during the week:
Hours of operation during the weekend:

QUESTIONS	**YES**	**NO**	**COMMENTS**
Is there a maternity ward in the center?			
Is there a delivery room? Please comment on the number of beds in the delivery room			
Doctor visits at the center			
Number of nurses in the department			
Nurse for FP/RH			
Condition of the health center: 1. Very clean 2. Clean 3. Somewhat clean 4. Less clean 5. Not clean			
Comments at the end of the visit.			

Report/Trend Chart

Ask the health center managers to show you the record for the past months, and if possible, verify the following:

QUESTIONS	YES	NO	COMMENTS
How are the medications registered?			
Are any types of contraceptive methods registered?			
Are there any family planning services?			
Is there a records department?			
Who performs family planning and IEC counseling?			
Are some IEC materials available?			
Delivery Room			
How many deliveries took place over the last 3 months?			
How many women were treated for delivery complications (transferred to the hospital)?			
Vaccination			
Are vaccination cards available for clients?			
Does the room have a cooling system?			
Laboratory			
Does the laboratory have a type of registration? If yes, which (specify)?			

Does the center have the following facilities?

Facilities	YES	NO	COMMENTS: Electricity, drinking water, lighting in the room, ventilation, laboratory, maternity equipment, contraceptive methods (the most used)
Waiting room			
FP/RH room			
Examination room			
Laboratory			
Pharmacy			
Maternity ward			
Emergency room			
Other			

Is this equipment available?

Equipment	YES	NO	COMMENTS
Examination table			
Instrument case			
Stethoscope			
Pinard stethoscope			
Blood bags			
Antiseptics			
Sterile gloves			
Autoclaves			
Sterilizer			
Syringes			
Stools			
Benches			
Toilets			
Linens			
Mirror			
Curtain			

ANNEX 5

IMPLEMENTATION PLAN

1. OBJECTIVE

To ensure quality family planning services for men and women of childbearing age in the nature conservation zones of the 10th ecological corridor (Graueri Landscape) in the eastern part of the DRC.

2. STRATEGIES

- Community-based distribution
- Clinical family planning services for cases referred by CBD workers

3. PRIMARY ACTIVITIES

A. Plea

Advance Africa will make a plea for the use of family planning and optimal birth spacing to secure the health of mothers and children and reduce maternal and infant mortality rates.

Targets: Officials from NGOs, churches, and community associations.

B. Awareness

The National Reproductive Health Program and SANRU recently produced outreach materials to promote the use of family planning. The reproduction of these materials will be complemented by the production of banners, advertising boards, and t-shirts.

C. Training

Advance Africa will organize trainings in cooperation with the Programme National de Santé de la Reproduction (PNSR) and SANRU. The training will involve providers, traditional birth attendants, and community-based distributors.

D. Monitoring

Advance Africa will establish a field data collection program to monitor the work of community-based distributors who are responsible for organizing awareness activities and distributing contraceptives.

Clinical services are responsible for organizing and monitoring awareness sessions and documenting information on administered contraceptive methods. These activities should be summarized monthly and a report should be sent to Advance Africa each quarter.

4. PRODUCTS EXPECTED

- Proposal
- Awareness report
- Training report
- Contraceptives and condom usage report, clinical services operation report, and community-based distributors work report
- Monthly and quarterly report on the use of contraceptive products

5. BUDGET

DESCRIPTION	TOTAL COST
Cost of proposal sessions, kits, contraceptive products, clinical equipment, a computer for monitoring and evaluation, and the shipment of products and materials	$60,000
Cost of awareness sessions, educational materials, banners, transportation and meals for leaders, and radio/televised broadcasts	$40,000
Training: • Organization of preparation meetings • Handling and transportation of trainers • Document printing • Handling of support staff • Purchase of office equipment	$25,000
Monitoring: • Transportation cost • Per diem	$7,500
$132,500	

ACTIVITIES SCHEDULE

N°	ESSENTIAL TASKS	PERIOD 2004 - 2005												PRODUCT	RESPONSIBLE PARTY
		1	2	3	4	5	6	7	8	9	10	11	12		
1	Proposal	*		*										Plea meeting report	Advance Africa, SANRI, LEADERS
2	Awareness	*	*	*	*	*	*	*	*	*	*	*	*	Awareness report	Advance Africa, UGADEC, and VIH Humanitaire.
3	Training	*	*											Training report	Advance Africa, SANRU, Community Associations
4	Contraceptive products, equipment, and management tools	*	*	*	*	*	*	*	*	*	*	*	*	Receipt or delivery slip	Advance Africa, Logistics
5	Monitoring and evaluation	*	*	*	*	*	*	*	*	*	*	*	*	Evaluation results report	Advance Africa

N°	ESSENTIAL TASKS	TARGET GROUP
1	**PROPOSAL** 1.1. Organize a cooperative framework of community associations. 1.2. Contact political and administrative authorities.	Local authorities Church officials Traditional authorities Officials from NGOs and community associations
2	**ORGANIZE AWARENESS ACTIVITIES** 2.1. Prepare educational aids 2.2. Make televisions available 2.3. Organize radio and televised programs 2.4. Organize awareness campaigns	Youth and adolescents Men Women Health care professionals Media professionals
3	**TRAINING** 3.1. Establish training programs 3.2. Organize training sessions • Training of trainers for community-based distributors and traditional birth attendants • Training of community-based distributors • Training of traditional birth attendants	Community-based distributors Traditional birth attendants Health care providers
4	**Placement of contraceptive products, equipment, and management tools** 4.1. Establishment of management tools 4.2. Purchase of materials and equipment 4.3. Delivery and distribution	
5	**Monitoring and Evaluation** 5.1. Monitoring Document and report on all activities 5.2. Evaluation Organize supervision in coverage areas and evaluate recorded results	All activities scheduled in the Graueri Landscape health areas